

ELLIOT, (J. W.)

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A CASE OF CHRONIC SALPINGITIS; TUBO-OVARIAN CYST, ACUTELY INFLAMED. HEMORRHAGE INTO THE CYST OPERATION. RECOVERY.

BY

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ON May 16th, 1886, I was asked by Dr. Worcester, of Waltham, to see a patient with pelvic inflammation, who was not doing well.

Mrs. S., aged 39 years, had been married twenty years. She had always been well before marriage. One year after marriage, she had a child. During this pregnancy, she suffered from a pain in her right side. After the child was born, she was sick in bed for several weeks. She thought that a part of the after-birth did not come away immediately, but gradually sloughed out, causing a very disagreeable white discharge. Since then, she had never been well. During the next two or three years, she had two miscarriages. She said she had "had womb trouble for ten years," and had been treated by several doctors, one of whom told her that she had "catarrh of the womb." Within the last four years, she had had three severe hemorrhages, which occurred at intervals of about one year. Otherwise the catamenia had been regular, but profuse. For the last ten years, she had been disabled during menstruation. She had pain in the back before the flow began, pain across the abdomen during the first two days, and tenderness several days later. Her right side had always troubled her, and whenever she took cold it was especially tender and painful. She had had a white discharge ever since her marriage, and for ten years had had occasional (six or eight in all) attacks of pain in the lower abdomen, accompanied by a discharge from the vagina of very offensive matter.

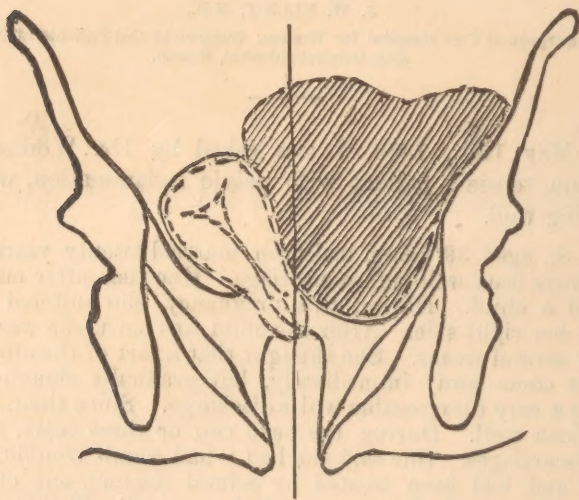
About three weeks before I saw her, she had taken cold, while

at work in the garden, during menstruation. She then began to be very tender across the lower abdomen, and to flow profusely, and soon became feverish and quite ill. On May 1st, Dr. Worcester was called, and found pain and tenderness in the right groin and iliac fossa, also in the right hypochondrium, with some resistance on pressure. Temperature 100° F., pulse 100. He ordered poultices, hot douches, and morphine. A week later the vaginal discharge became very offensive, the pain and tenderness were increasing, and the temperature was gradually rising.

On May 15th, condition unchanged.

When I saw her on May 16th, she had a yellowish-white color, and seemed to be quite ill. The temperature was about 100° F.

FIGURE I



She had a profuse bloody discharge, which was extremely offensive in spite of frequent douches. On examination, I found a fluctuating tumor, which filled the right side of the pelvis, extending two inches above the pubes. This tumor was tender, but movable within certain limits, and seemed to extend towards and to cling to the right side of the pelvis. The uterus could be felt small and hard, pushed somewhat to the left and slightly backwards, but entirely separate from the tumor. See Fig. 1.

Dr. Worcester had examined the day before, and had found no tumor. Its growth must therefore have been rapid. The general appearances were very suggestive of a pelvic abscess, but the very bad smell of the blood discharged led me to think that it must have been retained somewhere before it appeared in the vagina.

As the uterus was small and hard, it seemed to me to follow that the blood must come from the Fallopian tube, where it was retained, and formed the tumor which I had felt, but was slowly leaking out through the uterus and vagina.

I confirmed Dr. Worcester's diagnosis of pelvic inflammation, and gave my opinion that the tumor was probably a pelvic abscess, but that it might be a hemorrhage into the Fallopian tube. I advised waiting a day or two, and carefully watching the course of the disease, with preparations for an operation at short notice. The next day, I was notified by Dr. Worcester that the

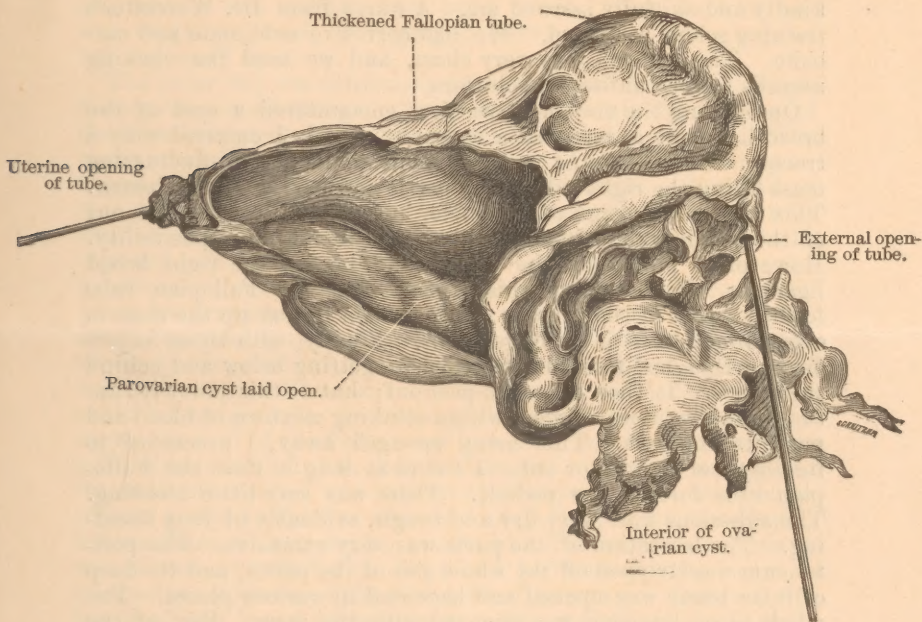


FIG. 2.—Chronic salpingitis, tubo-ovarian cyst, parovarian cyst.

temperature was higher, and that the patient was not so well, and was asked to come out prepared to do what was necessary.

On May 18th, the following day, I found the temperature $102\frac{1}{2}^{\circ}$ F., the pulse 120. The tumor had almost doubled in size in two days, and could be plainly felt, extending nearly up to the umbilicus. The foul discharge of blood had almost entirely stopped. It was very noticeable that the tumor as it grew still hugged the right side. My previous suspicion of hemorrhage into the Fallopian tube seemed to be confirmed by this rapid increase in size. But this increase might also occur with an abscess, and the high temperature certainly suggested pus formation. I was in great doubt whether it was best to aspirate and

drain the tumor per vaginam, or to do laparotomy at once. Dr. Worcester favored laparotomy, and suggested that the stinking discharge would make the vagina a septic field of operation.

I decided to do laparotomy, believing that I had a Fallopian tube to deal with, but thinking that if it should turn out to be an abscess, I could drain it the more thoroughly from above and below.

The operation was done in a small kitchen. Although I had brought my instruments, the operation must be regarded as an emergency operation, as I was not prepared for such a very serious affair as it turned out to be. Drs. Cutler and Worcester most kindly and skilfully assisted me. A nurse from Dr. Worcester's training school etherized. We had corrosive sublimate and carbolic. The kitchen was very clean, and we used the cooking utensils for our antiseptic solutions.

On opening the abdomen, we first encountered a cyst of the broad ligament as large as a cocoanut, which I emptied with a trocar. Then I found a large, thick-walled, semi-fluctuating mass filling the right side of the pelvis and part of the abdomen. This mass had no sign of a pedicle, but seemed to grow flat out of the pelvic wall. Its removal seemed to me an impossibility. However, I pulled up the uterus, and ligated the right broad ligament. While doing this, I saw that the Fallopian tube formed a part of the tumor. I began then to tear up the mass in every direction with my finger nails. Finally, with three fingers deep in Douglas' fossa, I succeeded in getting below and behind the tumor. It then began to peel out; but at this point it ruptured, and we were deluged with a stinking mixture of blood and pus, its contents. This being sponged away, I proceeded to forcibly tear the tumor out. I found at length that the Fallopian tube formed the pedicle. There was very little bleeding. The adhesions were very dry and tough, evidently of long standing. The laceration of the parts was very extensive. The peritoneum was stripped off the whole side of the pelvis, and the deep cellular tissue was opened and lacerated in various places. The whole broad ligament was removed with the mass. Part of the cyst came away in shreds, and small portions were left sticking to the pelvic wall. After sponging out, a glass drainage-tube was placed in the pelvis, and the patient put to bed. The operation was begun after 4 o'clock in the afternoon, and lasted two hours. The mass removed proved to be a most interesting specimen. It was the right Fallopian tube, very much *thickened* and elongated (hypertrophied), *only slightly dilated*, full of pus and blood, and glued to a suppurating ovarian cyst, forming the so-called tubo-ovarian cyst. There was also a cyst of the broad ligament. Fig. 2.

Under Dr. Worcester's most excellent after-treatment, the patient recovered rapidly. The temperature rose to 101° F., and fell to normal on the third day, when the drainage-tube was re-

moved. There was no vomiting, and no morphia was given until the third day.

Dr. R. H. Fitz, Professor of Pathology at the Harvard Medical School, kindly furnished me with the following minute description of the specimen:

DEAR DOCTOR ELLIOT:—The further examination of your specimen resulted as follows: The Fallopian tube was dilated, tortuous, and elongated to the extent of nearly six inches. Its wall was in general at least one-eighth of an inch thick, and in places, corresponding with the beginning of the varicosities, nearly twice as thick. The thickened wall was dense and white, the mucous and middle coats being fused. The inner surface was rough, injected, of a grayish-brown color, with specks of red and snuff color.

The outer end was intimately connected with a sacculated cyst as large as a small orange. There was no sharply defined line of demarcation between the two, nor were fimbriæ to be seen. The cavity of the cyst and the canal of the tube communicated by an opening about one-eighth of an inch in diameter. The wall of the cyst was thick and dense, intimately connected with the tube and the broad ligament. Its inner surface was in part smooth, injected, and hemorrhagic, in part with numerous minute depressions, in which were soft yellow plugs. Elsewhere a reticulated appearance was seen. The wall presented here and there tough, opaque, gray, intimately adherent patches, while elsewhere partly attached fibrinous masses were found. The wall was abundantly cellular and injected, but no epithelial structure could be recognized. In tearing the cyst from the broad ligament, the wall of the former was torn into, and found to contain a flat clot one-third of an inch in diameter. It lay in a cavity, to the walls of which it was intimately adherent. The microscope showed at the border line abundant large fatty degenerated cells, but no characteristic structural details. The surrounding tissue was fibrous, provided with large and tortuous vessels, but with no absolute evidence of the structure of an ovary. Between the layers of the broad ligament was a thin-walled cyst, collapsed, perhaps as large as an orange. Its wall was smooth, shining, easily isolated. It was lined with a cylindrical epithelium.

The diagnosis is as follows:

Chronic salpingitis; tubo-ovarian (?) cyst, acutely inflamed parovarian cyst. [Signed] R. H. FITZ.

MAY 20TH, 1886.

From the history of the case and the appearances of the specimen, it seems that the salpingitis must have existed for at least ten years (its origin being uncertain). Its course was chronic, as evidenced by the absence of acute symptoms and by the enormous thickening of the walls of the tube. The tube became glued to the ovary, and formed with it a thick-walled

cyst, which contained pus. Its contents were occasionally discharged through the uterus. On taking cold during menstruation, this tubo-ovarian cyst became acutely inflamed, giving rise to pain, fever, and finally to hemorrhage. At first, the blood trickled out through the tube, uterus, and vagina; later it was partially retained, causing distention of the cyst; finally it was almost entirely retained (probably on account of swelling of the tube), giving rise to rapid and extreme enlargement of the cyst and to alarming symptoms.

The case is, I believe, unique in more respects than one. I have been unable to find another recorded case where the external appearance of blood has led to the diagnosis of hemorrhage into the tube. This extreme thickening with only moderate dilatation of the tube is also uncommon.

The result of the operation was a singular confirmation of the diagnosis, in that the two conditions suggested (pelvic abscess or hemorrhage into the tube) were found to exist in combination.

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